

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04990**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>minutes</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>Box 143, Brady Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT</b> <span style="float: right;">First</span> <b>PAUL</b> <span style="float: right;">Middle</span> <b>AREFORD</b> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> <b>May</b> <span style="float: right;">Month</span> <b>12</b> <span style="float: right;">Day</span> <b>1961</b> <span style="float: right;">Year</span>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>March 13, 1917</b>		<b>9. AGE</b> (In years last birthday) <b>44</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>44</b> Days <b>44</b>	<b>IF UNDER 24 HRS.</b> Hours <b>44</b> Min. <b>44</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Mechanic, Auto</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Service station</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Morgantown, W.Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>George F. Areford</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Adda Sharpnack</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-10-1853</b>		<b>17. INFORMANT</b> <b>Mrs. Robert P. Areford, Cresaptown, Md.</b> <span style="float: right;">Address</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <b>Myocardial Infarction, left; Massive</b>            DUE TO <b>Coronary Occlusion</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Sclerosis, old; also recent thrombus</b> </div> <div style="width: 65%;">           (b) <b>Coronary Occlusion</b>            DUE TO <b>Sclerosis, old; also recent thrombus</b>            (c)         </div> </div>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Years</b> <b>-----</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <b>Benedict Skitarelic, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>May 12, 1961</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5/15/61</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Cumberland, Maryland</b>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Hafer, Cumberland, Maryland</b> <span style="float: right;">ADDRESS</span>				<b>24a. REC'D BY REGISTRAR</b> <b>MAY 16 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Caroline E. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **04991**

**5001**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FLINTSTONE</u>		c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FLINTSTONE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROUTE 2</u>				d. STREET ADDRESS <u>ROUTE 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>FORD</u> <u>ASH</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May XX</u> , <u>17</u> <u>19 61</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 16, 1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>ABRAM ASH</u>				14. MOTHER'S MAIDEN NAME <u>MARIAN WILSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-34-6439</u>		17. INFORMANT Address <u>VERNA ASH ROUTE 2, FLINTSTONE, MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>  <u>***</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 17, 1961</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 19, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ASH CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FLINTSTONE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BYRON KIGHT</u>				ADDRESS <u>CUMBERLAND, MD.</u>		24a. REC'D BY REGISTRAR <u>MAY 22 61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				DATE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

042207

5001



Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature. The form is divided into several horizontal sections with various labels and checkboxes.



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ALLGARY

WARRIAGE

ALLGARY

IN

CLERKSHIP

SI 0013

COOPERLAND

WESTERN HOSPITAL  
NORTH & MEMORIAL AVENUE

11, 1901

WY

WAGLEY

DECEASED

ROY

23

MAY 23, 1901

WHITE

WHITE

U. S. A.

BEACON COUNTY, N. Y.

WHITE SPINE

DECEASED BRIGHTLY

EMERALD HOSPITAL - EMERALD, N. Y.

8:15 AM

50 GREENE ST., COOPERLAND, N. Y.

DR. B. G. COOPER

May 14, 1901 Cooks Mills Cemetery, Ryndman, Pa. Burial

Ryndman, Pa.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5003

04993

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> <span style="float: right;">c. LENGTH OF STAY IN 1b 53 yrs.</span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>26 Laing Ave.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b> d. STREET ADDRESS <b>26 Laing Ave.</b> <span style="float: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First <b>Anna</b></span> <span>Middle <b>May</b></span> <span>Last <b>Bird</b></span> </div>			<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>Month <b>May</b></span> <span>Day <b>17</b></span> <span>Year <b>19 61</b></span> </div>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>Jan. 23, 1882</b>		<b>9. AGE</b> (In years last birthday) <b>79</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Martinsburg, W. Va.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>William Porterfield</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Clark</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>no</b>				
<b>17. INFORMANT</b> <b>Mrs. James Bittner, Cumberland, Md.</b>			<b>Address</b> <b>Cumberland, Md.</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>None</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 days</b> <b>Years</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner) <b>422.1</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 2-19-1959 to 5-17-1961 that (I) (we) last saw the deceased alive on 5-17-1961 and that death occurred at 4 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> 					<b>22b. DATE SIGNED</b> <b>5-19-61</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>G. Overton Himmelwright, M.D.</b>					<b>22d. ADDRESS</b> <b>133 Virginia Ave.-Cumberland, Md.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>May 20, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Hillcrest Burial Park</b>			
<b>23d. LOCATION</b> (City, town or county) (State) <b>Cumberland, Md.</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James F. Scarpelli, Cumberland, Md.</b>			<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE MAY 23 '61</b>				

MEDICAL CERTIFICATION

TO HOW ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Allegany  
Cumberland  
25 1st Ave.  
Bird  
White  
House  
With  
Mrs. James H. Hatcher, Cumberland, Md.

I

James H. Hatcher, Cumberland, Md.  
Bird  
White  
House  
With  
Mrs. James H. Hatcher, Cumberland, Md.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5004

## CERTIFICATE OF DEATH

Reg. Dist. No. 04994

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 mo., 3 das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>		d. STREET ADDRESS <b>531 B Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Boch</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 9, 1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry William O'Baker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Francis A. Boch</b> Address <b>LaVale Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>452 Chronic myocardial degeneration</b> 592X DUE TO <b>592 Chronic suppurative</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>153 Malignant neoplasm of Rectum</b> (c) <b>506 Psychosis &amp; cerebral arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>506 Psychosis &amp; cerebral arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 19th, 1961</b> to <b>May 22, 1961</b> , that I last saw the deceased alive on <b>May 20th, 1961</b> , and that death occurred at <b>1:20 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D. <b>49 Greene St.</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>		<b>49 Greene St., Cumberland, Md.</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b> ADDRESS <b>Cumb. Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5005

## CERTIFICATE OF DEATH

04995

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>40 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>MARYLAND</b> f. COUNTY <b>ALLEGANY</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> h. STREET ADDRESS <b>202 WILMONT AVENUE</b> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>SCHILLER C. BONIG</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>MAY 27 19 61</b>		<b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>MARCH 7, 1906</b> <b>9. AGE</b> (In years last birthday) <b>55</b> yrs. IF UNDER 1 YEAR: Months <b>00</b> Days <b>00</b> IF UNDER 24 HRS.: Hours <b>00</b> Min. <b>00</b>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>TIRE CO.</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>CHARLES A. BONIG</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA M. SCHILLER</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> <b>214 07 0015</b> <b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> DUE TO <b>Cirrhosis Liver</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>581.0</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>May 27, 1961</u>, that (I) (we) last saw the deceased alive on <u>May 27, 1961</u>, and that death occurred at <u>1:40 PM</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>GEORGE M. SIMONS</b>		<b>22b. ADDRESS</b> <b>ALGONQUIN HOTEL, CUMBERLAND, MD.</b>		<b>22d. DATE SIGNED</b> <b>22e. SIGNATURE</b> <b>Charles L. Kneave</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>MAY 29, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>SUNSET MEMORIAL PARK</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>BYRON KIGHT</b>		<b>24b. ADDRESS</b> <b>CUMBERLAND, MD.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles L. Kneave</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL  
MEMORIAL HOSPITAL AVENUE

SCHILLER

WHITE

MALE

CHARLES A. BONING

WILLIAM M. SCHILLER

HOSPITAL HOSPITAL, CUMBERLAND, MD.

10 DAYS

CUMBERLAND

505 MILKWEED AVENUE

BONING

MAY

XXV

10 APRIL 1, 1906

CUMBERLAND, MARYLAND

U.S.A.

GEORGE H. SHONS

ALLEGANY HOSPITAL, ALLEGANY, MD.

1003

04222

TO HOA: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5006

CERTIFICATE OF DEATH

04996

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN lb <b>Lifetime</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>227 Race Street</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>227 Race Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma J. Brant</b>		4. DATE OF DEATH Month Day Year <b>May 20, 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1883</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Charles Rosenmarkel</b>		15. MOTHER'S MAIDEN NAME <b>Barbara Bauer</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Herman F. Brant</b>		Address <b>227 Race St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocarditis &amp; Decompensation</b> 3 yrs. DUE TO (c) <b>Atherosclerosis</b> 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) (County) (State) <b>June 19, 1961 to July 20, 1961</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1961</b> to <b>July 20, 1961</b> that (I) (we) last saw the deceased alive on <b>May 20, 1961</b> and that death occurred at <b>19:30</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.		22b. DATE SIGNED <b>May 20, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b>		22d. ADDRESS <b>236 Virginia Ave. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-24-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

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Charles H. Johnson

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## CERTIFICATE OF DEATH

04997

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
CUMBERLAND		48 DAYS		CUMBERLAND		316 FAYETTE STREET									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
LILLIAN						BROTEMARITE		MAY		12		19		61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		* 6-11-2 1874		86? yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Housewife		Own Home		Maryland		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
William Mellenger		Adaline Hamill													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
NO		None		CHART		Sacred Heart Hospital									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		331X		DUE TO		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Hypertension		DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
Hour a. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>													
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5-9-1961, and that death occurred at 12:18 P.M., from the causes and on the date stated above.															
22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
Leo H. Ley, Jr.		7/3/61		Dr. Leo H. Ley, Jr., M.D.		456 N. Centre Street									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
Burial		May 13, 1961		Rose Hill Cemetery		Cumberland, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Byron Knight		Cumberland, Md.		MAY 17 '61											



1007

OFFICE OF THE

04883



MAILED 1007

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5008		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						04998			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penn.</b> b. COUNTY <b>Clarion</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mayport</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>						d. STREET ADDRESS <b>75X-3</b>					
3. NAME OF DECEASED (Type or print) First <b>Douglas</b> Middle <b>Scott</b> Last <b>Bullers</b>						4. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>3/29/59</b>		9. AGE (In years last birthday) <b>2</b> yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <b>Katanning, Pa.</b>						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>					
13. FATHER'S NAME <b>Robert Bullers</b>						14. MOTHER'S MAIDEN NAME <b>Virginia Ann Snyder</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Robert Bullers, Mayport, Pa.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1st &amp; 2nd Degree Burns of Face</b> <b>Body Arms &amp; Legs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4 hours</b> (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>Burned in fire in their Trailer Home</b>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <b>May 31 1961</b>						20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>						20f. (City or town) <b>Frostburg</b> (County) <b>Allegany</b> (State) <b>MD</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>WOMcLane</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>WOMcLane MD</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <b>May 31 1961</b>					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/3/1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Reynoldsville</b>				22d. LOCATION (City, town, or county) (State) <b>Reynoldsville PA.</b>	
23. FUNERAL DIRECTOR <b>GEORGE EICHHORN</b>						ADDRESS <b>LONACONING, MD.</b>		24a. REC'D BY REGISTRAR <b>JUN 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Klaus</b>	

MEDICAL CERTIFICATION

RR040

8008

(M)

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "EXAMINE" and "REPORT" are faintly visible.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, the certificate should be executed by the Deputy Medical Examiner. Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
5009																			
04999																			
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Perm.</b> b. COUNTY <b>Clarion</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mayport</b>														
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <b>75X-3</b>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jeffrey Phillip Bullers</b>					4. DATE OF DEATH Month Day Year <b>5/31/1961 19</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/5/1958</b>		9. AGE (In years last birthday) <b>2 yrs.</b>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Brookville, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days <b>9 26</b>											
13. FATHER'S NAME <b>Robert Bullers</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Ann Snyder</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Robert Bullers, Mayport, PA.</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1st &amp; 2nd Degree Burns of Face</b> DUE TO (b) <b>Body Arms &amp; Legs</b> DUE TO (c) <b>(FATHER)</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burned in fire in their Trailer Home</b>					20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8:00 May 31/1961</b>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>					20f. (City or town) (County) (State) <b>Frostburg Allegany Md</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>May 31/1961 Frostburg Md</b>									
ACTUAL SIGNATURE <b>W O McLane</b>					EXAMINER'S NAME (Type) <b>W O McLane</b>					22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>6/3/1961</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Reynoldsville,</b>					22d. LOCATION (City, town, or county) (State) <b>Reynoldsville, PA.</b>									
23. FUNERAL DIRECTOR <b>GEORGE EICHORN</b>					ADDRESS <b>LONACONING, MD.</b>					24a. REC'D BY REGISTRAR <b>JUN 5 '61</b>									
										24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>									



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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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5011  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05001

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>I/I4/59</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Buskey</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/1873</b>
9. AGE (In years lost birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Cumberland U.S.A.</b>	
13. FATHER'S NAME <b>John T. Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Laura V. Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> DUE TO <b>592X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO <b>?</b> (c) <b>Chronic Nephritis</b> DUE TO <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile Deterioration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>I/I4/59</b> 19 to <b>5/7/61</b> 19, that (I) (we) last saw the deceased alive on <b>5/6/61</b> <b>7:30 PM</b> that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b>		22b. DATE SIGNED <b>5/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-9-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		25a. REC'D BY REGISTRAR <b>MAY 10 1961</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Hume</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05002

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)			
a. COUNTY				e. STATE			
ALLEGANY				MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
CUMBERLAND				CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
SACRED HEART DECATUR STREET				213 W. 2nd ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
Marie JOSEPHINE				5 27 1961			
5. SEX				6. COLOR OR RACE			
FEMALE				WHITE			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
				#3/14/89			
9. AGE (In years last birthday)				10. IF UNDER 1 YEAR			
72 yrs.				Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
House Wife				Ownhome			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
ITALY Crechio Chiete				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ANTHONY BAZEELI (DECEASED)				Mary Darocco (DECEASED)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)			
No				None			
17. INFORMANT				Address			
CHART							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				10 yrs			
422.2 DUE TO				10 yrs			
Conditions, if any, which gave rise to immediate cause (b)							
(e), stating the underlying cause last, DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour e.m. p.m. 19				While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1950 to 5-27-61, that (I) (we) last saw the deceased alive on 5-27-61 and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Dr. J. T. Johnson, Jr.							
22c. NAME (Type)				22d. ADDRESS			
DR. J. T. JOHNSON, M.D.				16 GREEN STREET CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
Burial				5-31-61			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Sunset Memorial Park				Cumberland, Md			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
James F. Scarpelli Cumberland, Md.				25b. REGISTRAR'S SIGNATURE			
				MAY 31 '61			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5013  
CERTIFICATE OF DEATH  
05003

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>428 SEYMOUR STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>VIOLET G. CLAY</b>				4. DATE OF DEATH <b>MAY 9, 1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DECEMBER 5, 1908</b>	
9. AGE (In years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES PAGUE</b>				14. MOTHER'S MAIDEN NAME <b>GEORGIANA MC KINNEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes give number or date of service) <b>no</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> DUE TO <b>myocarditis &amp; Decomposition</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Pulmonary Metastases from Carcinoma of L. Breast</b> DUE TO <b>3 mm</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Left mastectomy for Carcinoma Sept 1960</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 9, 1960</b> to <b>May 9, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 9, 1961</b> , and that death occurred at <b>9:05 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clay E. Durrett</b>				22b. DATE SIGNED <b>5/9/61</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>	
22d. ADDRESS <b>303 GRAND AVE., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneib</b>	

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403 BRAD AVE. THUNDERBOLT, MO.

DR. CLAY E. DORRITT

5-11-1961 ST. MARY'S HOSPITAL, THUNDERBOLT, MO.

THUNDERBOLT, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5014											
05004											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>11 DAYS</b>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MARYLAND</b>							
3. NAME OF DECEASED (Type or print) <b>NELLIE G. CLINE</b>				4. DATE OF DEATH <b>5 25 19 61</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-27-92</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Elk Garden WEST, VIRGINIA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>				13. FATHER'S NAME <b>GEORGE WARNER (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN KENNEY (DECEASED)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-22-6718</b>				17. INFORMANT <b>Thomas A. Cline Cumberland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac or Pulmonary Infarction</b> <b>154X</b> DUE TO (b) <b>Cardiac Dysrhythmia</b> (c) <b>Aneurysm - abdominal - spinal section</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>Years</b> <b>6 days.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma uterine extending into vagina</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumberland, Md.</b>		(State) <b>(State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 <b>5-25</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5-25</b> , 19 <b>61</b> , and that death occurred at <b>5-25</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Carlton Brinsfield</b>				22b. DATE SIGNED <b>5-27-61</b>				22c. PHYSICIAN'S NAME (Type) <b>CARLTON BRINSFIELD M.D.</b>			
22d. ADDRESS <b>232 BALTIMORE AVE. CUMBERLAND, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5-29-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Patrick Cem.</b>		23d. LOCATION (City, town or county) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5015						05008					
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					
c. LENGTH OF STAY IN 1b <b>16 DAYS</b>						d. STREET ADDRESS <b>31 MEMORIAL AVENUE</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>SUDIE</b> Middle <b>Virginia</b> Last <b>CRUMITT</b>						4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>1961</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 6, 1882</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Virginia Brunswick, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>PAUL LONG</b>						14. MOTHER'S MAIDEN NAME <b>MARY FRANCIS VALENTINE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatitis coma</b> 420.1 DUE TO (b) <b>Jaundice</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Portal cirrhosis</b> <b>coronary arteriosclerosis; myocardial fibrosis;</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cont'd.Lt. ventricular hypertrophy; pulmonary fibrosis;</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>17 days</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>cont'd.calcification aorta; hypertension</b>							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>4/25</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/25</b> , 19 <b>61</b> to <b>5/11</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/11</b> , 19 <b>61</b> , and that death occurred at <b>9:10A.M.</b> the causes and on the date stated above.											
22a. SIGNATURE <i>Samuel M. Jacobson</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/13/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. SAMUEL M. JACOBSON</b>						22d. ADDRESS <b>50 PERSHING ST., CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>MAY 16 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Haug</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health.

5016  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05007

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>523 Cumberland, Street</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>523 Cumberland Street</b>	
3. NAME OF DECEASED (Type or print) <b>Genevieve R. Cullen</b>		4. DATE OF DEATH <b>May 27, 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>R.</b>	8. DATE OF BIRTH <b>10-27-1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	9. AGE (In years last birthday) <b>67</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Allegany County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Timothy Cullen</b>		14. MOTHER'S MAIDEN NAME <b>Bridget Donahue</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>192-09-8643</b>	
17. INFORMANT <b>Mrs. Hohn M. Bryson</b>		Address <b>Cumberland, Md., 523 Cumberland St.,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> DUE TO (b) <b>Carcinoma of Cervix</b> DUE TO (c) <b>22 mos</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8 Aug 1959</b> to <b>27 May 1961</b> , that (I) (we) last saw the deceased alive on <b>26 May 1961</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James G. Stegmaier</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>James G. Stegmaier, M.D.</b>		22d. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/30/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUN 2 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Hanes</b>			

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Handwritten signature and text at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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5017

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05008

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brostburg</b>				c. LENGTH OF STAY IN TB <b>15 Hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First Middle Last <b>FRANCIS CUNNINGHAM</b>		4. DATE OF DEATH <b>5 29 19 61.</b>		5. STREET ADDRESS <b>Box 110, R.D. #2 (Zihlman)</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-11-15</b>	
9. AGE (In years last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kaiser Alum.</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Zihlman</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas H. Cunningham</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Allen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W.W.#2</b>				16. SOCIAL SECURITY NO. <b>212-10-6308</b>			
17. INFORMANT <b>Miss Gertrude Cunningham, Washington, D.C.</b>				18. ADDRESS <b>Apt. 105 19 Ridge Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Broncho Pneumonia</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Emphysema &amp; Pulmonary Fibrosis</b> (c) <b>2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 28 1961</b> to <b>May 29 1961</b> , that (I) (we) last saw the deceased alive on <b>May 28 1961</b> , and that death occurred <b>May 29 1961</b> at <b>5:15 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>WOMcLane</b>				22b. DATE SIGNED <b>May 30 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>WOMcLane MD</b>				22d. ADDRESS <b>Frostburg Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5-31-61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harfer Funeral Home</b>				25a. REC'D BY REGISTRAR <b>June 2 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>							

05008

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5018					CERTIFICATE OF DEATH						
060					05009						
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>32 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MOOREFIELD</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>					d. STREET ADDRESS <b>85X-3</b>						
3. NAME OF DECEASED (Type or print) <b>MINNIE</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>1961</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 24, 1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>DURGON, W. VA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>AMBY HARPER</b>					14. MOTHER'S MAIDEN NAME <b>ELLEN JUDY</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. — — — — —						
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac failure</b> 429.0 DUE TO <b>A.S. and Hypertensive Heart disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Chr. arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>Acute Pericarditis, Complicated by Intestinal Hemorrhage</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>3 years</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4 May 1961</b> to <b>19 May 1961</b> , that (I) (we) last saw the deceased alive on <b>18 May 1961</b> and that death occurred at <b>8:00AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>W. Alfred Van Ormer</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>					22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 21-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ</b>		23d. LOCATION (City, town or county) (State) <b>Moorefield - W. Va.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Thum</b>					25a. REC'D BY REGISTRAR <b>MAY 31 '61</b>					25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>	



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WEST VIRGINIA

ALABAMA

MOBILE

IN 1913

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WASHING & MOUNTAIN VIEW

WASHING & MOUNTAIN VIEW

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NOVEMBER 21, 1913

WHITE

DETROIT, MICH.

WEST VIRGINIA

ELLEN ALVA

MEMORIAL HOSPITAL, CUMBERLAND, MD.

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The patient was  
admitted to the  
hospital on November 21, 1913.  
The patient was  
found to be in a  
state of collapse.

*Handwritten notes:*  
The patient was  
found to be in a  
state of collapse.

NOV 21 1913

DR. V. A. VAN DUSEN

102 S. CENTRE ST., CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5019

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05010

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany Street</b>				d. STREET ADDRESS <b>Allegany Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Baker</b> Last <b>Dick</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1961</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1884</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agent</b>		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Thomas Dick</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Schulyler</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Thomas Dick Lonaconing, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Hypertensive Cardiovascular Renal Disease</b> DUE TO (c) <b>years -</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1955</b> to <b>May 23, 1961</b> , that (I) ( <del>we</del> ) lost saw the deceased alive on <b>May 22, 1961</b> , and that death occurred at <b>2524</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>John B. Davis,</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>John B. DAVIS, MD</b>				22d. ADDRESS <b>2 Broadway, Frostburg, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		25a. RECEIVED BY REGISTRAR DATE <b>MAY 26 61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

5020

05011

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <b>7 N. Grant Street</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> d. STREET ADDRESS <b>7 N. Grant Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jessie Lucille Engle</b>				4. DATE OF DEATH <b>May 20th, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 30th, 1891</b>	
9. AGE (In years lost birthday) <b>70 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. - Pan Packager</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Murray</b>				14. MOTHER'S MAIDEN NAME <b>Susan Arnold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>280-22-0302</b>		17. INFORMANT <b>Elmer Engle, 7 N. Grant St. Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C-V disease</b> DUE TO (c) <b>5 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-1</b> to <b>5-20</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5-20</b> 19 <b>61</b> , and that death occurred at <b>6:130 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>H. C. Diehl</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>H. C. Diehl</b>		22d. ADDRESS <b>39 W. Main Street, Frostburg, Md.</b>		22b. DATE SIGNED <b>5/22/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-23-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Burt</b>		ADDRESS <b>Frostburg, Md.</b>		25a. REG'D BY REGISTRAR <b>MAY 24 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Howard</b>	

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CONFIDENTIAL

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1. The purpose of this document is to provide a summary of the information received from the source. The information is classified as Confidential and is to be handled accordingly.

2. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

3. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

4. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

5. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

6. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

7. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

8. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

9. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

10. The source has provided information regarding the activities of the group. The information is being provided for your information and is not to be disseminated outside of your office.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5021

## CERTIFICATE OF DEATH

05012

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>20 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MORGAN</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PA W PAW</b> d. STREET ADDRESS <b>c/o Postmaster</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROBERT C. FAWVER</b>		<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>19</b> Year <b>19 61</b>					
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JUNE 16, 1892</b>	<b>9. AGE</b> (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>MARTINSBURG, W. VA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>			
<b>13. FATHER'S NAME</b> <b>WILLIAM G. FAWVER</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>MARY E. AMBROSE</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>232-10-4837</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Left Lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Probably 3-4 yrs.</b>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>April 1959</b> to <b>May 19 1961</b> , that (I) (we) last saw the deceased alive on <b>May 19 1961</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Calvin Y. Hadidian</b>		<b>22b. DATE SIGNED</b> <b>MAY 19 1961</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>DR. CALVIN Y. HADIDIAN</b>			
<b>22d. ADDRESS</b> <b>WASHINGTON &amp; CUMBERLAND STS., CUMBERLAND, MD.</b>		<b>22e. REC'D BY REGISTRAR</b> <b>MAY 23 '61</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>5/23/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>CAMP HILL</b>			
<b>23d. LOCATION</b> (City, town or county) <b>PAW PAW</b>		<b>(State)</b> <b>W. VA.</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>PARKS-JOHNSON</b>		<b>25a. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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RECEIVED & PAID  
HOSPITAL

ROBERT

EDWARD

MAY 18

MALE

WHITE

ALICE 16, 1905

WASHINGTON, D. C.

MARY E. AMERSON

WILLIAM D. TAYLOR

RECEIVED HOSPITAL - CHICAGO, ILL.

*Division of Staff*

May 18

May 18

DR. EDWIN A. HODGSON

WASHINGTON & CHICAGO STS., CHICAGO, ILL.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05013

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1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>				d. STREET ADDRESS <b>Rt. #1, Oldtown</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>LEE</b> Last <b>FLETCHER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1951</b>		9. AGE (In years last birthday) <b>10</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard W. Fletcher</b>				14. MOTHER'S MAIDEN NAME <b>Betty Kinser</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Richard W. Fletcher, Rt. #1, Oldtown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MACERATION OF BRAIN, INTRACRANIAL HEMORRHAGE</b> DUE TO <b>GUNSHOT WOUND</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 Days</b> (c) <b>2 Days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Accidental gunshot wound of right nostril</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>5:30</b> <b>May 1</b> <b>19 61</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Oldtown, Alleg. Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 3, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/6/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Twigg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fletcher Farm, Near Oldtown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAY 4 61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5023

05014

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>1821 BEDFORD ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GEORGE C FREY</b>		First		Middle		Last		4. DATE OF DEATH <b>5/18/61</b>		Month		Day		Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/11/75</b>		9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Embalmer &amp; Funeral Director</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Conrad Frey</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Seiss</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Disease</b> (c) <b>Myocardial Infarction</b>		DUE TO		DUE TO		DUE TO		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from <b>5/18</b> 19 <b>61</b> , to <b>5/18</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/18</b> 19 <b>61</b> , and that death occurred at <b>8:50 A</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Leo H. Ley, Jr.</b>		22b. DATE SIGNED <b>5/18/61</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY, JR.</b>		22d. ADDRESS <b>456 N CENTER STREET</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Mausoleum</b>		23b. DATE THEREOF <b>5-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) <b>Cumberland, Md.</b>		(State)									
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md</b>		25a. REC'D BY REGISTRAR <b>MAY 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoms</b>											

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James T. Postville, Vermont, 1000  
Rose Hill, Vermont, 1000  
Rose Hill, Vermont, 1000

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 05015

5024

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>02 Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Lynn St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>OLIA</b> Middle <b>BERNADETTE</b> Last <b>GARRETT</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1899</b>
9. AGE (In years lost birthday) yrs. <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Deer Park, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John R. Browning</b>		14. MOTHER'S MAIDEN NAME <b>Lucinda J. Walters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-22-6536</b>	
17. INFORMANT <b>Mr. Charles Garrett</b>		Address <b>607 Lynn St. Cumb.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Status after CVA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 - 25, 1954</b> to <b>5 - 2, 1961</b> , that I last saw the deceased alive on <b>4 - 25, 1961</b> , and that death occurred at <b>7 a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		DATE SIGNED <b>5-3-61</b>	
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin M. D.</b>		ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/5/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. K...</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05016

5025

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>1 Wk.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>700 Brookfield Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>EVERETT</b> Last <b>GROVES</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1961</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1928</b>		
9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech. Dept.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>K-S Tire Company</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Everett C. Groves</b>				14. MOTHER'S MAIDEN NAME <b>Mildred Harrison</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>46-48 50-51 216-22-6550</b>		17. INFORMANT <b>Gerald Groves, Frostburg, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Right</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 4, 1961</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1902

1

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1902		Newark, N.J.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Burial	
Heart Disease		Myocarditis		Chest Pain		10:30 AM		Catholic Cemetery	
Occupation		Education		Marital Status		Previous Illness		Signature of Examiner	
Clerk		High School		Married		None		J. H. Smith, M.D.	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Medical Examiner		Signature of Burial Officer	
J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.		J. H. Smith, M.D.	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05017

5026

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART</b>				d. STREET ADDRESS <b>216 CENTRAL AVE.</b>			
3. NAME OF DECEASED (Type or print) First <b>BERNARD</b> Middle <b>Golden</b> Last <b>HARDY</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 21, 1895</b>		9. AGE (In years last birthday) <b>65</b> yrs.	10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired employee - Washington Terminal R.R.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Hardy</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hess</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>W W I</b>				16. SOCIAL SECURITY NO. <b>718-14-9748</b>		17. INFORMANT <b>Mrs. Josephine Hardy</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>2-4 Hrs.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 22, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 26, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				24a. REC'D BY REGISTRAR <b>MAY 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fraw</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

05013

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Physician		12. Signature of Nurse	
13. Signature of Undertaker		14. Signature of Burial Director		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Interment		18. Signature of Burial	
19. Signature of Burial		20. Signature of Burial		21. Signature of Burial	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial	
28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial	
34. Signature of Burial		35. Signature of Burial		36. Signature of Burial	
37. Signature of Burial		38. Signature of Burial		39. Signature of Burial	
40. Signature of Burial		41. Signature of Burial		42. Signature of Burial	
43. Signature of Burial		44. Signature of Burial		45. Signature of Burial	
46. Signature of Burial		47. Signature of Burial		48. Signature of Burial	
49. Signature of Burial		50. Signature of Burial		51. Signature of Burial	
52. Signature of Burial		53. Signature of Burial		54. Signature of Burial	
55. Signature of Burial		56. Signature of Burial		57. Signature of Burial	
58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial	
64. Signature of Burial		65. Signature of Burial		66. Signature of Burial	
67. Signature of Burial		68. Signature of Burial		69. Signature of Burial	
70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial	
79. Signature of Burial		80. Signature of Burial		81. Signature of Burial	
82. Signature of Burial		83. Signature of Burial		84. Signature of Burial	
85. Signature of Burial		86. Signature of Burial		87. Signature of Burial	
88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial	
94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial	
100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	

05013

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05018**

5027

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL RIDGELEY</b>		d. STREET ADDRESS <b>85X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ADAM</b> Middle <b>HERRICK</b> Last <b>HERRICK</b>				4. DATE OF DEATH Month <b>5</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/29/87</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b>		IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>		11. BIRTHPLACE (State or foreign country) <b>W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN ADAM HERRICK</b>				14. MOTHER'S MAIDEN NAME <b>MARY ABE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, left</b> DUE TO <b>420-1</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Thrombosis</b> (c) <b>420-1</b> DUE TO <b>420-1</b> stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitaralic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitaralic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 31, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Abe Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wiley Ford, W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 5 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kirsch</b>	

TO DEFEND MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5028

Item 4 Film G288

6/5/61 iwk

05019

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>32 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		d. STREET ADDRESS <b>62 Spring Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>NELLIE VIOLA HILL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 61</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10-1921</b>		9. AGE (In years last birthday) <b>39</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Midlothian, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Togans</b>		14. MOTHER'S MAIDEN NAME <b>Eloise Frazier</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Robert Hill, 62 Spring St., Frostburg, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Coronary occlusion</b> <b>arteriosclerotic heart disease</b> <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>1 year</b> <b>Indef.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (the hospital) attended the deceased from <b>April 1955</b> to <b>May 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 25, 1961</b> , and that death occurred at <b>7:24 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>John B. Davis, M.D.</b>		22b. DATE SIGNED <b>5/27/61</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS, MD</b>		22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD</b>		22e. RECEIVED BY REGISTRAR <b>DATE MAY 31 '61</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-28-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>		23e. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>		23f. ADDRESS <b>23 E. Main, Frostburg, Md.</b>									



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To H. A. D. + 1010

John B. Brown

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5029

05020

<b>1. PLACE OF DEATH</b> e. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG, MARYLAND</b> d. STREET ADDRESS <b>44 WEST COLLEGE AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ANNA C. HOTT</b>		<b>4. DATE OF DEATH</b> Month <b>5</b> Day <b>25</b> Year <b>1961</b>	
<b>5. SEX</b> <b>FEMALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>5-30-1897</b>
<b>9. AGE</b> (In years last birthday) <b>63 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST, VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>	
<b>13. FATHER'S NAME</b> <b>JOHN J. REILLY (DECEASED)</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>SARAH (MALLOW) REILLY (DECEASED)</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>44-20-1</b>	
<b>17. INFORMANT</b> <b>Alfred Hott</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA - 2° to Kidney Failure</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Heart and Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>10 weeks</b> <b>2 years</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>myocardial infarction</b>	
<b>20a. TIME OF INJURY</b> Hour e.m. <b>19</b> p.m.		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20d. (City or town)</b> <b>Frostburg Md</b>	
<b>20e. (County)</b> <b>Allegany</b>		<b>20f. (State)</b> <b>Md</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5/25/61</b> <b>to</b> <b>5/25/61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>5/25/61</b> , <b>and that death occurred at</b> <b>7:15 A.M.</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>S.G. Wesiman</b>		<b>22b. DATE SIGNED</b> <b>5/27/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>S.G. WESIMAN M.D.</b>		<b>22d. ADDRESS</b> <b>59 GREENE STREET, CUMBERLAND, MD</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify).</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5-27-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Frostburg Md</b>		<b>23d. LOCATION (City, town or county)</b> <b>Frostburg Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. R. Dunt</b>		<b>25. REGD BY REGISTRAR</b> <b>MAY 29 1961</b>	
<b>25a. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>	

1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5030

05021

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>3 Years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>207 Laing Avenue</b>				d. STREET ADDRESS <b>207 Laing Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Lizetta</b> Middle <b>Elizabeth</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1961</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 24, 1876</b>		9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>				11. BIRTHPLACE (State or foreign country) <b>New York City</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Martin Roedel</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth Fight</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles W. Johnson</b>				18. Address <b>207 Laing Avenue, Cumberland, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO <b>Carcinoma Rectum</b> Conditions: If any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Carcinoma Rectum</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 1958</b> to <b>1961</b> , that (I) (we) last saw the deceased alive on <b>1 May 1961</b> and that death occurred at <b>3:02 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Fuller B. Whitworth</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Fuller B. Whitworth, M.D.</b>						22d. ADDRESS <b>123 Bedford St. Cumberland, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 3, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hill Grove Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Connellsville Penna</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>						ADDRESS <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 3 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. E. S. T. T. T.</b>					

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05022

5031

Item 8 Film G288 6/7/61 4wk

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Barrelville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>CLINTON</u> Last <u>KELLEY</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1892/1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>	
11. BIRTHPLACE (State or foreign country) <u>Gilmore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Kelley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Jane Boyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>208-09-5660</u>	
17. INFORMANT <u>Mrs. George C. Kelley, Barrelville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR PULMONALE, MARKED</u> <u>523.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SILICOSIS; EMPHYSEMA</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, left lower lobe; terminal</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>May 29, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 31, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Partick's Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Savage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>George S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
5032 CERTIFICATE OF DEATH 05023													
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL &amp; WARWICK AVES. MEMORIAL HOSPITAL</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>GOLDEN LANE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>KATHRYN E. KIRCHNER</b>			4. DATE OF DEATH <b>MAY 17, 1961</b>			5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>MAY 29, 1953</b>			9. AGE (In years last birthday) <b>7 yrs.</b>			10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>ROY KIRCHNER</b>						14. MOTHER'S MAIDEN NAME <b>RUTH WILKES</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>							
17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> DUE TO <b>Hemorrhagic chickenpox</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>9 days</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1961</b> to <b>May 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1961</b> , and that death occurred at <b>10:10 P.M.</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>R. A. Reiter</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>May 17, 1961</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. R. A. REITER</b>						22d. ADDRESS <b>112 BEDFORD ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/20/61</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial</b>			23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hefner</b>						ADDRESS <b>Cumberland, Maryland</b>			25a. REC'D BY REGISTRAR <b>MAY 22 '61</b>				
									25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				

10833

3033



ALLEGANT

ALLEGANT

ALLEGANT

CUMBERLAND

CUMBERLAND

CUMBERLAND

GOLDEN LANE

GENERAL HOSPITAL  
1001A & 1011A WYCK OFFICE

MAY 13

MAY 13

MAY 13

MAY 13

MAY 13, 1953

MAY 13, 1953

U. S. A.

U. S. A.

ROY KIRCHNER

ROY KIRCHNER

GENERAL HOSPITAL - CUMBERLAND, MD.

*Handwritten notes:*  
The patient is a 35-year-old male, white, with a history of hypertension and a recent diagnosis of myocardial infarction. He is currently in the hospital, and his condition is stable. The patient is being treated with aspirin and nitroglycerin. The patient is being discharged on May 13, 1953.

X

10:10

*Handwritten signature:* Dr. J. J. Bester

115 BEDFORD ST., CUMBERLAND, MD.

DR. J. J. BESTER

Dr. J. J. Bester

Dr. J. J. Bester

Dr. J. J. Bester

Dr. J. J. Bester

Dr. J. J. Bester

*Handwritten signature:* Dr. J. J. Bester

the funeral director, page 3 should be filled with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5033  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05024

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>15 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. STREET ADDRESS <b>1419 OLDTOWN RD.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>HENRY</b> Last <b>KNIPPENBERG</b>				4. DATE OF DEATH <b>MAY 9 1961</b> Month <b>9</b> Day <b>9</b> Year <b>61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 26, 1878</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED RAILROAD</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR</b>		11. BIRTHPLACE (State or foreign country) <b>Greenspring, W.Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>HENRY KNIPPENBERG (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>KATE LUTISHA LOGSDON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>PATIENT'S CHART</b>		17. INFORMANT <b>PATIENT'S CHART</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 year</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-1</b> <b>1961</b> , to <b>5-9</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>5-9</b> <b>1961</b> , and that death occurred at <b>11:30</b> <b>AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Brings</b>				22b. DATE SIGNED <b>5/10/61</b>		22c. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b>	
22d. ADDRESS <b>55 GREENE ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 12 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kirsch</b>	

MEDICAL CERTIFICATION

(M)

(J)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **65025**

**5034**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>1 Hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>Main</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Ellsworth Lamberson</b> <span style="font-size: small;">First Middle Last</span>				4. DATE OF DEATH <b>May 31 1961</b> <span style="font-size: small;">Month Day Year</span>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 12, 1930</b>	
9. AGE (in years last birthday) <b>31</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>		11. BIRTHPLACE (State or foreign country) <b>Barton-Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Maurice B. Lamberson</b>				14. MOTHER'S MAIDEN NAME <b>Louise Myers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-24-2006</b>		17. INFORMANT <b>Jean E. Lamberson</b> <span style="float: right;">Address <b>Barton, Md.</b></span>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>W O Mc Lane</b>		EXAMINER'S NAME (Type) <b>W. O. MC Lane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 31, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/3/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Boal</b>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 5 '61</b> DATE	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5035

05028

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale</b>				c. LENGTH OF STAY IN 1b <b>35 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>352 Mc Henry Street</b>				d. STREET ADDRESS <b>352 Mc Henry Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>CECIL</b> Last <b>LANCASTER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 19, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Edward Lancaster</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Rephann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Mrs. Arthur C. Lancaster, La Vale, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>150X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>carcinoma of the esophagus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 mo</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4-3-</b> <b>1961</b> , to <b>5-8-</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>5-6-</b> <b>1961</b> , and that death occurred at <b>4 A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>L Brings</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS</b>				22d. ADDRESS <b>57 Greene St. Cumberland Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 10, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Eckhart, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAY 12 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hafer</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5036

## CERTIFICATE OF DEATH

Reg. Dist. No.

65027

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
c. LENGTH OF STAY IN 1b <u>Lifetime</u>		d. STREET ADDRESS <u>Walnut Level Farm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>G.</u> Last <u>Layman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7th</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7th, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John N. Layman</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fazenbaker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>J. Horace Layman, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1960</u> , 19 <u>  </u> to <u>May 7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>May 6</u> , 19 <u>61</u> , and that death occurred at <u>8:00 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. O. McLane</u>		DATE SIGNED <u>May 9 1961</u>	
PHYSICIAN'S NAME (Type) <u>W. O. McLane,</u>		" <u>167 E. Main Street, Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-9-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Russell</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

CERTIFICATE OF DEATH

*[The following text is mirrored bleed-through from the reverse side of the document and is not legible.]*

NAME OF DECEASED: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

IMMEDIATE CAUSE OF DEATH: \_\_\_\_\_

UNDERLYING CAUSE OF DEATH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

SEX: \_\_\_\_\_

RACE: \_\_\_\_\_

EDUCATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

RELIGION: \_\_\_\_\_

MARRIED: \_\_\_\_\_

PREVIOUS ILLNESS: \_\_\_\_\_

PREVIOUS SURGERY: \_\_\_\_\_

PREVIOUS TRAUMA: \_\_\_\_\_

PREVIOUS DRUGS: \_\_\_\_\_

PREVIOUS ALCOHOL: \_\_\_\_\_

PREVIOUS TOBACCO: \_\_\_\_\_

PREVIOUS OTHER: \_\_\_\_\_

PREVIOUS MEDICATION: \_\_\_\_\_

PREVIOUS TREATMENT: \_\_\_\_\_

PREVIOUS DIAGNOSIS: \_\_\_\_\_

PREVIOUS PROGNOSIS: \_\_\_\_\_

PREVIOUS OUTCOME: \_\_\_\_\_

PREVIOUS COMMENTS: \_\_\_\_\_

PREVIOUS SIGNATURE: \_\_\_\_\_

PREVIOUS DATE: \_\_\_\_\_

PREVIOUS PLACE: \_\_\_\_\_

PREVIOUS NAME: \_\_\_\_\_

PREVIOUS TITLE: \_\_\_\_\_

PREVIOUS ORGANIZATION: \_\_\_\_\_

PREVIOUS ADDRESS: \_\_\_\_\_

PREVIOUS CITY: \_\_\_\_\_

PREVIOUS STATE: \_\_\_\_\_

PREVIOUS ZIP: \_\_\_\_\_

PREVIOUS COUNTRY: \_\_\_\_\_

PREVIOUS PHONE: \_\_\_\_\_

PREVIOUS FAX: \_\_\_\_\_

PREVIOUS EMAIL: \_\_\_\_\_

PREVIOUS WEBSITE: \_\_\_\_\_

PREVIOUS SOCIAL MEDIA: \_\_\_\_\_

PREVIOUS OTHER: \_\_\_\_\_

PREVIOUS SIGNATURE: \_\_\_\_\_

PREVIOUS DATE: \_\_\_\_\_

PREVIOUS PLACE: \_\_\_\_\_

PREVIOUS NAME: \_\_\_\_\_

PREVIOUS TITLE: \_\_\_\_\_

PREVIOUS ORGANIZATION: \_\_\_\_\_

PREVIOUS ADDRESS: \_\_\_\_\_

PREVIOUS CITY: \_\_\_\_\_

PREVIOUS STATE: \_\_\_\_\_

PREVIOUS ZIP: \_\_\_\_\_

PREVIOUS COUNTRY: \_\_\_\_\_

PREVIOUS PHONE: \_\_\_\_\_

PREVIOUS FAX: \_\_\_\_\_

PREVIOUS EMAIL: \_\_\_\_\_

PREVIOUS WEBSITE: \_\_\_\_\_

PREVIOUS SOCIAL MEDIA: \_\_\_\_\_

PREVIOUS OTHER: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5037

05028

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>33 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
3. NAME OF DECEASED (Type or print) <b>ALVIN J. LEHMAN</b>		4. DATE OF DEATH <b>MAY 30, 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 23, 1900</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R. R.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>OWEN ALVIN LEHMAN</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN BONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214- 07- 1144</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cordial Failure</b> 443 X DUE TO (b) <b>arteriosclerosis and Hypertension long known disease. 2 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Open. arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 8 hours</b> ? <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Stomach at. fort, sends to alone, amputation mid. thigh 5/25/61</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10:00 AM</b> to <b>3:00 PM</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>30 May</b> , 19 <b>61</b> , and that death occurred at <b>7:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. Alfred Van Ormer</b>		22b. DATE SIGNED <b>2 June 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 5 '61</b>	
ADDRESS <b>Cumberland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

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ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

32 DAYS

CUMBERLAND

RT. 22, WILLIAMS ROAD

MEMORIAL HOSPITAL  
WILKINSON & MEMORIAL AVENUES

61

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1931

MEMORIAL

4

ALVIN

61

MAY 23, 1932

WHITE

MALE

U. S. A.

CUMBERLAND, MD.

Box 100

ELLEN BONE

OVER ALVIN HENRY



MEMORIAL HOSPITAL - CUMBERLAND, MD.

*[Faint, mostly illegible handwritten notes and signatures in the center of the page.]*

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1:30 PM

1932 10 21

*[Faint handwritten signature or text.]*

152 S. CLINTON ST., CUMBERLAND, MD.

DR. W. A. VAN COTT

*[Faint text at the bottom of the page, possibly a footer or additional notes.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be removed to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any other event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5038

## CERTIFICATE OF DEATH

05029

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN b <b>10 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>RT.#4, BOX 42</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>MARY</b>		Middle <b>V.</b>		Last <b>LONG</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 18, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <b>MAY 23 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>W.VA. PETERSBURG</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L. EVANS</b>				14. MOTHER'S MAIDEN NAME <b>MARY J. BROWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-07-5481</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>I hope this thrombosis began in <u>Petersburg</u></b> <b>Ardenwester Church Church House</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>years.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Resident Central Union Accident</b>				INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1959</b> to <b>May 1961</b> , that (I) (we) last saw the deceased alive on <b>May 23 1961</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>G. Overton Himmelwright</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/23/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>				22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 26, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 31 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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(M)

ALLEGANY

WARRAND

ALLEGANY

10 DAYS

COVERLAND

MEMORIAL HOSPITAL  
TEMPORARY A WARDEN AVES.

ST. PAUL, BOX 12

INDY

V.

LOIS

WAY

CO

41

FEMALE WHITE

X

JULY 18, 1903

ST

Housewife

Own Home

W.VA. INTERVIEWED

U.S.A.

JOHN L. EVANS

MARY J. BROWN

ST. PAUL - 1001 MEMORIAL HOSPITAL, CINCINNATI, MO.

no

*Copy to the ...*  
*...*

*...*

C. OVERTON HILLBRIGHT

133 VIRGINIA AVE., CINCINNATI, MO.

Nov 10, 1901 St. Bernard Cemetery, Cincinnati, Mo.

James P. MacFarland, Cincinnati, Mo.

Nov 10, 1901





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## 05030

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Allegany</u></span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. 1, Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rt. 1, Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>/</u>	
<b>3. NAME OF DECEASED</b> (Type or print)		<b>4. DATE OF DEATH</b>	
First <u>Anna</u> Middle <u>Mary</u> Last <u>Madden</u>		Month <u>May</u> Day <u>10th</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14th, 1894</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Demonstrator Sewing Machine</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ambrose Morris</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Louise Neus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>358-07-1074</u>	
17. INFORMANT <u>Miss Sarah Morris, Rt. 1, Frostburg, Md.</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>May 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 3, 1961</u> , and that death occurred on <u>May 10, 1961</u> at <u>7:34</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. O. McLane</u>		22b. DATE SIGNED <u>May 10, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. O. McLane</u>		22d. ADDRESS <u>167 E. Main St., Frostburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-13-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. P. Curst</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 12 '61</u>	
ADDRESS <u>Frostburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65031

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. SAVAGE</b> d. STREET ADDRESS <b>RT. #1,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>T.</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 5, 1905</b>		9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISABLED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MARTIN (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH WATKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-10-1244</b>		17. INFORMANT <b>Wm. L. Martin</b> Address <b>PATIENTS CHART R.D. #1, Mt. Savage, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>circulation of heart &amp; arteries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>coronary disease</b> DUE TO <b>coronary disease</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>May 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 9, 1961</b> , and that death occurred at <b>Md.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>B. M. Schindler</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>BLANE M. SCHINDLER, M.D.</b>	
22d. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-12-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Savage Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Beulah H. Montague</b>				25a. REC'D BY REGISTRAR <b>MAY 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Fries</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05032

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>45 Minutes</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ECKHART</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>MART</b> Last <b>IRANO</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 8, 1907</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOUSEWORK</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>SALVATORE ZUMPANO</b>		14. MOTHER'S MAIDEN NAME <b>VINCENZA ROSANOVA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>PATIENT'S CHART</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardio-vascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4 - 15</b> 19 <b>56</b> , to <b>5 - 6</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5 - 6</b> 19 <b>61</b> , and that death occurred at <b>9</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>RALPH W. BALLIN, M.D.</b>		22d. ADDRESS <b>62 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-9-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Duval</b>		25a. REC'D BY REGISTRAR <b>MAY 10 '61</b>	
ADDRESS <b>FROSTBURG, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frazier</b>	

05038

EXHIBIT A OF 05038

05038



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1-10

General Manager

2-10

Assistant Manager

1-10

2-10

3-10

4-10

1-10

2-10

1-10

General Manager

1-10

Assistant Manager

General Manager

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5042  
CERTIFICATE OF DEATH

65033

(M)

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGIA</b> Middle <b>A.</b> Last <b>MAUS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-13-1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE PRATT</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN LARKIN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give number and date of service)			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma Breast</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>5 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>60</b> <b>5 P.M.</b> , that (I) (we) last saw the deceased alive on <b>May 16</b> , 19 <b>61</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Walter P. James</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/18/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. P. JAMES</b>				22d. ADDRESS <b>441 N. CENTRE STREET, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 19, 61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery Cumberland Md</b>	
23d. LOCATION (City, town or county)				23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							



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(1)

ALLIANCE

CONVENTION

MEMORIAL HOSPITAL

GEORGIA

WHITE

GEORGE PRATT

3 DAYS

A. T. WINS

11-13-1988

MARYLAND

ELLEN LARKIN

CONVENTION

5 S. MICHIGAN STREET

MAY

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ALLIANCE

MARYLAND

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16 51

U.S.A.

MEMORIAL HOSPITAL - CONVENTION, MARYLAND

DR. M. T. HARRIS

301 N. CENTRE STREET, CHICAGO, ILL.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5043  
CERTIFICATE OF DEATH  
05034

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b> c. LENGTH OF STAY IN 1b <b>3 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Fairport Harbor</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>307 6th Street</b> d. STREET ADDRESS <b>307 6th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <b>Deborah Dianna McAlpine</b>				4. DATE OF DEATH Month Day Year <b>May 10 1961</b>											
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-27-60</b>									
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days		11. IF UNDER 24 HRS. Hours <b>1</b> Min.		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Cleveland, Ohio.</b>							
13. FATHER'S NAME <b>Charles L. McAlpine</b>				14. MOTHER'S MAIDEN NAME <b>Phyllis J. Wright</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>							
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Charles L. McAlpine, 307 6th Street, Ohio</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute gastro-enteritis</b> (b) <b>Severe dehydration</b> (c) <b>Severe dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Severe dehydration</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Severe dehydration</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>5-9 1961</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) <b>Frostburg</b>				20g. (County) <b>Frostburg</b>				20h. (State) <b>Md.</b>							
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>5-9</b> , 19 <b>61</b> , to <b>5-10</b> , 19 <b>61</b> , that (I) <b>(no)</b> last saw the deceased alive on <b>5-10</b> , 19 <b>61</b> , and that death occurred at <b>1:38 P.M.</b> from the causes and on the date stated above.								22a. SIGNATURE <b>H.C. Diehl</b>				22b. DATE SIGNED <b>5/10/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>				22d. ADDRESS <b>Frostburg, Md.</b>				22e. ADDRESS <b>Frostburg, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5-12-1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>							
23d. LOCATION (City, town or county) <b>Frostburg</b>				23e. (State) <b>Md.</b>				23f. (Country) <b>U.S.A.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montross</b>				24a. ADDRESS <b>23 E. Main, Frostburg, Md.</b>				24b. REC'D BY REGISTRAR <b>MAY 15 '61</b>							
24c. REGISTRAR'S SIGNATURE <b>Arthur L. Fries</b>				24d. ADDRESS <b>Frostburg, Md.</b>				24e. (State) <b>Md.</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5044  
CERTIFICATE OF DEATH  
Item 9 Film G287 5/18/61 iwk  
65035

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>55yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>532 Necessity St.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>532 Necessity St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lena M. McArdle</b>		4. DATE OF DEATH <b>May II, 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1886</b>
9. AGE (In years last birthday) <b>74 64 yrs.</b>		IF UNDER 1 YEAR: Months <b>7</b> Days <b>4</b> Hours <b>64</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Everson, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Cornelius Miller</b>		14. MOTHER'S MAIDEN NAME <b>Anna C. Pressman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Mrs. ##### Clara Leasure 532 Necessity</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>42010</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>2 years</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-3-1961</b> to <b>5-11-1961</b> , that (I) (we) last saw the deceased alive on <b>5-9-1961</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Lewis</b>		22b. DATE SIGNED <b>5/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lewis Brings</b>		22d. ADDRESS <b>55 Green St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-14-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James F. Scarpelli Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 16 '61</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Lewis</b>	

00083

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June 7, 1886

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5045

05036

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>1 Wk.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First		Middle		Last	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-24-1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. DATE OF DEATH <b>5 5 19 61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Worker Kelly Tire Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly Tire Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Frostburg</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>James McGann</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Durkin</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>			
16. SOCIAL SECURITY NO. <b>220-18-7165</b>				17. INFORMANT <b>Miss Anna McGann, 11 Washington St., (Dght)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 293X DUE TO Secondary anemia (b) <b>Secondary anemia</b> (c) <b>Secondary anemia</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-27-1961</b> to <b>5-5-61</b> , that (I) (we) last saw the deceased alive on <b>5-4-1961</b> , and that death occurred on <b>5-5-61</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H.C. Diehl</b>				22b. DATE SIGNED <b>5/6/61</b>		22c. PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>	
22d. ADDRESS <b>FROSTBURG, Md.</b>				22e. DATE <b>5/6/61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Mt. Savage, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 9 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>				25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kinn</b>			

19204



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5046

## CERTIFICATE OF DEATH

06295

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg - rural</b>	
c. LENGTH OF STAY IN 1b <b>several years</b>		d. STREET ADDRESS <b>RD #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Augustus W. Meyers</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>9</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Oct. 10, 1906</b>
<b>9. AGE</b> (In years last birthday) <b>54</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>54</b> Days <b>19</b> Hours <b>61</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>self-employed - Trucker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Trucking</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Somerset Co., Pa.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles Meyers</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Platter</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>214-03-5266</b>	
<b>17. INFORMANT</b> <b>Mrs. Anna M. Meyers, RD#1, Frostburg, Maryland</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>415X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Chr. Rheumatic Fever</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 mo.</b> <b>years</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>9:20 AM</b> e.m. <b>May 9</b> p.m. <b>1961</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>July 4, 1960</b> <b>May 9</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>May 9</b> , 19 <b>61</b> , and that death occurred at <b>9:20 AM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>W. O. McLane</b>		<b>22b. DATE SIGNED</b> <b>May 9/1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>W. O. McLane, MD</b>		<b>22d. ADDRESS</b> <b>Frostburg, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>May 12, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>I.O.O.F. Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Rockwood, Somerset Co., Pa.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. J. Wood, Rockwood, Pa.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 12 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Walter L. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5047

05037

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>4/26/60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>E.</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/10/1884</b>	
9. AGE (In years last birthday) <b>76</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own housework</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Lehr</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Workman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>P/O Box 599 Cumberland, Md.</b>			
17. INFORMANT <b>Allegany County Infirmary, records</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Chronic Nephritis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myocardial Degeneration</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>4/26/60</b> 19 to <b>5/8/61</b> 19, that (I) (we) lost the deceased alive on <b>5/8/61</b> 19, and that death occurred <b>5:30 A.M.</b> on the causes and on the date stated above.							
22a. SIGNATURE <b>James E. McLean</b>				22b. DATE SIGNED <b>5/9/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>				22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5-12-61</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>St. George's Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. P. Ours</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 12 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65038

1. PLACE OF DEATH a. COUNTY <b>Allegheny</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b> c. LENGTH OF STAY IN 1b <b>37 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>135 Front St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegheny</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b> d. STREET ADDRESS <b>135 Front</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sarah</b> First <b>Catherine</b> Middle <b>Moon</b> Last 4. DATE OF DEATH <b>May</b> Month <b>26</b> Day <b>19</b> Year <b>61</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Feb. 18, 1888</b> 9. AGE (In years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XXXXXX</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>XXXXXX</b> 11. BIRTHPLACE (State or foreign country) <b>Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Adam Whetzel</b> 14. MOTHER'S MAIDEN NAME <b>Matilida Whetzel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Ira Whetzel</b> Address <b>McCoole, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Cardio Vascular Renal Disease</b> DUE TO <b>Obesity, Hypertension, arteriosclerosis</b> DUE TO <b>Diabetic Mellitus</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>R. W. Reeves</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <b>Raymond W. Reeves, M.D.</b> 22d. ADDRESS <b>Westernport, Maryland</b> 22b. DATE SIGNED <b>5/27/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>May 29, 1961</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem.</b> 23d. LOCATION (City, town, or county) (State) <b>Westernport, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>E. L. Boal</b> ADDRESS <b>Westernport, Maryland</b> 25a. REC'D BY REGISTRAR <b>MAY 31 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>	

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CHURCH OF THE DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05039

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN lb <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>226 Carroll St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernard F. Myers</b>		4. DATE OF DEATH Month Day Year <b>May 17 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob L. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Jenny Bell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) <b>No</b>		16. SOCIAL SECURITY NO. —	
17. INFORMANT <b>Miss Clara Myers</b>		Address <b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY SCLEROSIS</b> (c) <b>420.1</b> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> -----			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <b>May 17, 1961</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stenine</b>		ADDRESS <b>117 Frederick St. Cumb. Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 19 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	



## B: 2001-1981-1980-1979-1978-1977-1976-1975-1974-1973-1972-1971-1970-1969-1968-1967-1966-1965-1964-1963-1962-1961-1960-1959-1958-1957-1956-1955-1954-1953-1952-1951-1950-1949-1948-1947-1946-1945-1944-1943-1942-1941-1940-1939-1938-1937-1936-1935-1934-1933-1932-1931-1930-1929-1928-1927-1926-1925-1924-1923-1922-1921-1920-1919-1918-1917-1916-1915-1914-1913-1912-1911-1910-1909-1908-1907-1906-1905-1904-1903-1902-1901-1900-1899-1898-1897-1896-1895-1894-1893-1892-1891-1890-1889-1888-1887-1886-1885-1884-1883-1882-1881-1880-1879-1878-1877-1876-1875-1874-1873-1872-1871-1870-1869-1868-1867-1866-1865-1864-1863-1862-1861-1860-1859-1858-1857-1856-1855-1854-1853-1852-1851-1850-1849-1848-1847-1846-1845-1844-1843-1842-1841-1840-1839-1838-1837-1836-1835-1834-1833-1832-1831-1830-1829-1828-1827-1826-1825-1824-1823-1822-1821-1820-1819-1818-1817-1816-1815-1814-1813-1812-1811-1810-1809-1808-1807-1806-1805-1804-1803-1802-1801-1800-1799-1798-1797-1796-1795-1794-1793-1792-1791-1790-1789-1788-1787-1786-1785-1784-1783-1782-1781-1780-1779-1778-1777-1776-1775-1774-1773-1772-1771-1770-1769-1768-1767-1766-1765-1764-1763-1762-1761-1760-1759-1758-1757-1756-1755-1754-1753-1752-1751-1750-1749-1748-1747-1746-1745-1744-1743-1742-1741-1740-1739-1738-1737-1736-1735-1734-1733-1732-1731-1730-1729-1728-1727-1726-1725-1724-1723-1722-1721-1720-1719-1718-1717-1716-1715-1714-1713-1712-1711-1710-1709-1708-1707-1706-1705-1704-1703-1702-1701-1700-1699-1698-1697-1696-1695-1694-1693-1692-1691-1690-1689-1688-1687-1686-1685-1684-1683-1682-1681-1680-1679-1678-1677-1676-1675-1674-1673-1672-1671-1670-1669-1668-1667-1666-1665-1664-1663-1662-1661-1660-1659-1658-1657-1656-1655-1654-1653-1652-1651-1650-1649-1648-1647-1646-1645-1644-1643-1642-1641-1640-1639-1638-1637-1636-1635-1634-1633-1632-1631-1630-1629-1628-1627-1626-1625-1624-1623-1622-1621-1620-1619-1618-1617-1616-1615-1614-1613-1612-1611-1610-1609-1608-1607-1606-1605-1604-1603-1602-1601-1600-1599-1598-1597-1596-1595-1594-1593-1592-1591-1590-1589-1588-1587-1586-1585-1584-1583-1582-1581-1580-1579-1578-1577-1576-1575-1574-1573-1572-1571-1570-1569-1568-1567-1566-1565-1564-1563-1562-1561-1560-1559-1558-1557-1556-1555-1554-1553-1552-1551-1550-1549-1548-1547-1546-1545-1544-1543-1542-1541-1540-1539-1538-1537-1536-1535-1534-1533-1532-1531-1530-1529-1528-1527-1526-1525-1524-1523-1522-1521-1520-1519-1518-1517-1516-1515-1514-1513-1512-1511-1510-1509-1508-1507-1506-1505-1504-1503-1502-1501-1500-1499-1498-1497-1496-1495-1494-1493-1492-1491-1490-1489-1488-1487-1486-1485-1484-1483-1482-1481-1480-1479-1478-1477-1476-1475-1474-1473-1472-1471-1470-1469-1468-1467-1466-1465-1464-1463-1462-1461-1460-1459-1458-1457-1456-1455-1454-1453-1452-1451-1450-1449-1448-1447-1446-1445-1444-1443-1442-1441-1440-1439-1438-1437-1436-1435-1434-1433-1432-1431-1430-1429-1428-1427-1426-1425-1424-1423-1422-1421-1420-1419-1418-1417-1416-1415-1414-1413-1412-1411-1410-1409-1408-1407-1406-1405-1404-1403-1402-1401-1400-1399-1398-1397-1396-1395-1394-1393-1392-1391-1390-1389-1388-1387-1386-1385-1384-1383-1382-1381-1380-1379-1378-1377-1376-1375-1374-1373-1372-1371-1370-1369-1368-1367-1366-1365-1364-1363-1362-1361-1360-1359-1358-1357-1356-1355-1354-1353-1352-1351-1350-1349-1348-1347-1346-1345-1344-1343-1342-1341-1340-1339-1338-1337-1336-1335-1334-1333-1332-1331-1330-1329-1328-1327-1326-1325-1324-1323-1322-1321-1320-1319-1318-1317-1316-1315-1314-1313-1312-1311-1310-1309-1308-1307-1306-1305-1304-1303-1302-1301-1300-1299-1298-1297-1296-1295-1294-1293-1292-1291-1290-1289-1288-1287-1286-1285-1284-1283-1282-1281-1280-1279-1278-1277-1276-1275-1274-1273-1272-1271-1270-1269-1268-1267-1266-1265-1264-1263-1262-1261-1260-1259-1258-1257-1256-1255-1254-1253-1252-1251-1250-1249-1248-1247-1246-1245-1244-1243-1242-1241-1240-1239-1238-1237-1236-1235-1234-1233-1232-1231-1230-1229-1228-1227-1226-1225-1224-1223-1222-1221-1220-1219-1218-1217-1216-1215-1214-1213-1212-1211-1210-1209-1208-1207-1206-1205-1204-1203-1202-1201-1200-1199-1198-1197-1196-1195-1194-1193-1192-1191-1190-1189-1188-1187-1186-1185-1184-1183-1182-1181-1180-1179-1178-1177-1176-1175-1174-1173-1172-1171-1170-1169-1168-1167-1166-1165-116

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5050

## CERTIFICATE OF DEATH

Item 8 Film G288 5/26/61 mb

05040

1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>ALLEGANY, MD.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				STREET ADDRESS <b>ROUTE #3</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS R. O'HAVER</b>				4. DATE OF DEATH Month Day Year <b>MAY 11, 1961.</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>10-26-1889</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN W. O'HAVER</b>				14. MOTHER'S MAIDEN NAME <b>MARY DARR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/10/61</i> 19... to <i>5/11/61</i> 19..., that (I) <del>was</del> last saw the deceased alive on <i>5/10/61</i> 19..., and that death occurred at <i>8:15AM</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gaster-Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Garrett County Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS <b>Westernport, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 19 '61</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

1  
The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

11

ALLERDAY

CLINICAL

1 DAY

WATER & MEMORIAL HOSPITAL

WATER & MEMORIAL HOSPITAL

THOMAS

P.

WHITE

MALE

DIAGNOSIS

10-26-1952

WIRYLAND

U. S. A.

WIRYLAND

JOSEPH W. CHAMBER

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. B. J. WILLIAMS

155 S. CENTRE ST., CUMBERLAND, MD.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5051

05041

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL, 2201 MEMORIAL &amp; WARWICK AVES.,</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>213 SCHLEY STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>DORA</b> Middle <b>A.</b> Last <b>PARSONS</b>		<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>2</b> Year <b>1961</b>		<b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>JUNE 15, 1883</b>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months <b>7</b> Days <b>7</b> IF UNDER 24 HRS.: Hours <b>7</b> Min. <b>7</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>FROSTBURG, MD.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>JOHN ASPINALL</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MARIE KAEFER</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>—</b>		<b>17. INFORMANT</b> <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>April 30, 1961</b> to <b>May 2, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 2, 1961</b> , and that death occurred <b>7:00 AM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>B. M. Schindler</b>		<b>22b. DATE SIGNED</b> <b>5/3/61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>BLANE M. SCHINDLER</b>			
<b>22d. ADDRESS</b> <b>43 GREENE ST., CUMBERLAND, MD.</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>					
<b>23b. DATE THEREOF</b> <b>May 5, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Frostburg Memorial B. Park</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Frostburg Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Louis Steen, Inc. Cumberland, Md.</b>		<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles E. Hanna</b>			
<b>DATE</b> <b>MAY 8 '61</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1981

1981

ALLEGANY

WYOMING

CUTLERLAND

5 DAYS

QUEENSLAND

MEMORIAL HOSPITAL  
NEW MEMORIAL & WARDEN AVENUE

213 SCHLEY STREET

DEAD

PARTIAL

WY

61

FEMALE WHITE

AGE 12, 1981

77

JOHN ASHWELL

MARIE JAMES

MEMORIAL HOSPITAL, QUEENSLAND, NO.

(1)

BLAKE M. SCHMIDT

23 GREEN ST., QUEENSLAND, NO.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5052 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05042

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DOA Memorial Hospital</b>		d. STREET ADDRESS <b>Mc Kenzie Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SANDRA</b> Middle <b>KAY</b> Last <b>PENDERGAST</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1960</b>
9. AGE (In years last birthday) yrs. <b>5</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Thomas Pendergast</b>		14. MOTHER'S MAIDEN NAME <b>Rosetta Metzner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John T. Pendergast, La Vale, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b> DUE TO <b>ASPIRATION OF STOMACH CONTENTS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-6 Min.</b> <b>4-6 Min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ACUTE TRACHEOBRONCHITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>MAY 9, 1961</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Catholic Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cresaptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 1961</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





Item 20 Film 288  
5-31-61 5053

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05043

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>National Highway</b>				d. STREET ADDRESS <b>55 McCulloh St.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>PFAFF</b> Last				4. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>19 61</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-18-1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. PLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Davis</b>				14. MOTHER'S MAIDEN NAME <b>Mary James</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>220-16-7029</b>			
17. INFORMATION <b>James C. Pfaff, 55 McCulloh St.</b>				Address <b>Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED HEART; RUPTURED AORTA</b> DUE TO <b>816 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CRUSHED CHEST</b> DUE TO (c) <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Injured in 2 car automobile accident</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>10:50</b> a. m. <b>May 18</b> 19 <b>61</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 40 1 mi. E of Frostburg</b>				20f. (City or town) (County) (State) <b>Allegany Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W O McLane</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W.O. McLane, Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>May 19, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-21-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park Frostburg</b>		22d. LOCATION (City, town, or county) (State) <b>Ma.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home</b>				24a. REC'D BY REGISTRAR <b>May 23 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10/11/19

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK

10/11/19

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Signature of Coroner: \_\_\_\_\_

14. Signature of Registrar: \_\_\_\_\_

15. Signature of Witness: \_\_\_\_\_

16. Signature of Physician: \_\_\_\_\_

17. Signature of Nurse: \_\_\_\_\_

18. Signature of Chaplain: \_\_\_\_\_

19. Signature of Minister: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5054

05044

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Frostburg (Rural #1 Gilmore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		d. STREET ADDRESS <b>Frostburg (Rural #1 Gilmore</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM THOMAS PRESTON</b>		4. DATE OF DEATH <b>5/31/1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/6/1901</b>	
9. AGE (In years last birthday) <b>59</b>		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		12. CITIZEN OF WHAT COUNTRY <b>U-S-A</b>	
13. FATHER'S NAME <b>Meschisk Preston</b>		14. MOTHER'S MAIDEN NAME <b>Annie Crawford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>182-01-3566</b>	
17. INFORMANT <b>Mrs. William Preston, Gilmore, MD</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Massive; old and recent</b> (b) <b>Coronary Sclerosis with thrombosis</b> (c) <b>420.1</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. TIME OF INJURY Month, Day, Year <b>19</b>		22. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W D McLane</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>W D McLane MD</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>May 31/1961</b>			
Address (Street, city, town, or county) <b>Frostburg, Md</b>			
26. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		27. DATE THEREOF <b>6/3/1961</b>	
28. NAME OF CEMETERY OR CREMATORY <b>Old Coney Cemetery</b>		29. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
30. FUNERAL DIRECTOR <b>GEORGE EICHORN</b>		31. ADDRESS <b>LONACONING, MD.</b>	
32. REC'D BY REGISTRAR DATE <b>JUN 5 '61</b>		33. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

5055

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05045

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>1318 BEDFORD ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>A</b> Last <b>RICE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 6, 1881</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN N. RICE</b>		14. MOTHER'S MAIDEN NAME <b>OLIVE WAGNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. HAZEL RICE</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> DUE TO <b>9030</b> Conditions, if any, which gave rise to immediate cause (b) <b>COMPRESSION FRACTURE OF 2 md. Thoracic Vert.</b> DUE TO <b>36 Hrs.</b> cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 Hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>STUMBLED, FELL AND STRUCK BACK</b>	
20c. TIME OF INJURY Month, Day, Year <b>9</b> Hour <b>p. m.</b> <b>MAY 16 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) (County) (State) <b>CUMBERLAND ALLEGANY MARYLAND</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 17, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1961 MAY 27, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>	
24a. REC'D BY REGISTRAR <b>MAY 22 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. H... ..</b>	









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
65047														
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					c. LENGTH OF STAY IN lb <b>13 DAYS</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>JESSIE Helen ROBINETTE</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>19</b> Year <b>1961</b>									
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 26, 1909</b>		9. AGE (In years last birthday) <b>51</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <b>JOHN RAY</b>					14. MOTHER'S MAIDEN NAME <b>AGNES TRUE</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>14</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>CUMBERLAND</b>		20g. (County) <b>ALLEGANY</b>		20h. (State) <b>MARYLAND</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>May 1961</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>8:25 AM</b> from the causes and on the date stated above.										22b. DATE SIGNED <b>5/20/61</b>				
22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b>					22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>					22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) <b>Cumberland, Maryland</b>		23e. REC'D BY REGISTRAR <b>MAY 23 '61</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George Cumberland, Md.</b>										24b. ADDRESS				

VR A15 (4)  
15M 9/60

(M)

ALLEGANY

INVESTIGATED

ALLEGANY

MEMORIAL HOSPITAL  
WARRINGTON & MEMORIAL AVENUE

13 DAYS

CLASSIFIED

801 EIGHTH AVENUE

ESSIE

ROBINETTE

MAY

MAY

WHITE

MAY 26, 1900

21

INVESTIGATED

JOHN RAY

JOHN RAY

MEMORIAL HOSPITAL - GARFIELD, N.D.

*White (Name of Person)*

DR. G. OVERTON HINCHLINT

121 VIRGINIA AVE., GARFIELD, N.D.

*White (Name of Person)*  
*White (Name of Person)*  
*White (Name of Person)*

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05048

5058

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>323 Baltimore Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WADE KENNETH</u> Middle <u>ROOT</u> Last <u>ROOT</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19, 1908</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prod. Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Schmidts Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Thomas, West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>WILLIAM ROOT</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA SHAHAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-5086</u>		17. INFORMANT Address <u>Mrs. W. K. Root, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>May 22, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 25, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **05049**

5059

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>53 Marion St.</b>				d. STREET ADDRESS <b>153 Marion St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>A.</b> Last <b>Ruppert</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 21, 1898</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Months <b>6</b> Days <b>15</b> Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen Help.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Jacob H. Ruppert</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Starmann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>			
17. INFORMANT <b>Miss Phelonia Ruppert (Sister)</b>				Address <b>—</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma left breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4-10-61</b> , 19 <b>61</b> , to <b>5-15-61</b> , 19 <b>61</b> , that I lost saw the deceased alive on <b>5-9-61</b> , 19 <b>61</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>16 Green St. Cumberland, Md.</b> DATE SIGNED <b>5-16-61</b>							
ACTUAL SIGNATURE <b>James T. Johnson Jr.</b>				M.D. <b>16 Green St. Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>James T. Johnson Jr. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SS Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b> ADDRESS <b>117 Frederick St. Cumb. Md.</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

5028

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

CHIEF OF BUREAU



VR A1S (4)  
1SM 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5060

U59540

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
CUMBERLAND		55 days		03 CUMBERLAND		1439 BOND STREET									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION															
SACRED HEART															
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
HARRY						SHARRETTE		MAY		15		19		61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3-25-07		54 yrs.		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
CITY OF CUMBERLAND				MARYLAND		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
(DECEASED) John R. Sharretts		(DECEASED) Mary E. Howearth													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
yes		WV II		214-05-8889		CHART									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO		Esophageal Varices		INTERVAL BETWEEN ONSET AND DEATH									
5810															
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		(b)		Cirrhosis, hepatic											
		(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
		19													
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 5-15-1961, that (I) (we) last saw the deceased alive on 5-14-1961, and that death occurred at 7:40 M, from the causes and on the date stated above.															
22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
Leo H. Ley Jr.		5/17/61		LEO H. LEY JR.		456 N. Centre St.									
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)							
Burial		5/18/61		Summit Memorial Ph.		Cumberland MD									
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Lewis Stein Inc. Cumb. MD.				DATE MAY 19 '61		Charles P. Harris									

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **U5051**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W.VA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>13 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIEDMONT</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>4 E HAMPSHIRE STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>SHERREN</b> Last				4. DATE OF DEATH Month <b>5</b> Day <b>23</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/12/93</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM DAWSON</b>				14. MOTHER'S MAIDEN NAME <b>ANNA REYNOLDS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7-10 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochanteric fracture right femur</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in hall going from bed room to bath room</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>8</b> a. m. <b>May 9 1961</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Piedmont Mineral W. Va.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>May 23, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/26/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>*Philos</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. J. Boal</i>				ADDRESS <b>Westernport, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '61</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5062

05052

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY in 1b <b>42 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;"><b>ALLEGANY</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>14 Shiller</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>MARY Jane SHIPLEY</b>		<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>27</b> Year <b>1961</b>		<b>5. SEX</b> <b>FEMALE</b> <b>WHITE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>12-11-3 1884</b> <b>9. AGE</b> (In years last birthday) <b>76 1/2</b> yrs.		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>WEST VIRGINIA</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>William Taylor</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Sines</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>CHART</b> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure with Cerebral Edema</b> DUE TO (b) <b>Recent and Old Posterior Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic (atherosclerotic) Cardiovascular dis Years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus; Obesity; Acute occlusion, right popliteal vessels</b>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) <b>(Signature)</b> attended the deceased from <b>November</b> ....., 19 <b>58</b> to <b>May 27th</b> ....., 19 <b>61</b> , that (I) <b>for</b> last saw the deceased alive on <b>May 26th</b> ....., 19 <b>61</b> , and that death occurred at <b>2:20 a.m.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Wyand A. Doerner Jr</b>		<b>22b. DATE SIGNED</b> <b>5-28-61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>DR. WYAND DOERNER, JR., MD.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5/29/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Pleasant Grove Cemetery Near Cumberland Md</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John J. Acker Cumberland Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 31 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5063 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film 3287 5/24/61 jwk

Reg. Dist. No.

05053

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="float: right;">ALLEGANY</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">MARYLAND</span> CUMBERLAND c. LENGTH OF STAY IN lb 20 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 805 MARYLAND AVE.				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="float: right;">MARYLAND</span> b. COUNTY <span style="float: right;">ALLEGANY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 805 MARYLAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last CHARLES W. SHORT <b>4. DATE OF DEATH</b> Month Day Year MAY 18 19 61				<b>5. SEX</b> MALE <b>6. COLOR OR RACE</b> WHITE <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> May 25, 1889 <b>9. AGE</b> (In years last birthday) 71 yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) CARMAN		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> RAILROAD		<b>11. BIRTHPLACE</b> (State or foreign country) W. VA.		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> JAMES SHORT				<b>14. MOTHER'S MAIDEN NAME</b> ELIZABETH ADAMS			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) YES WW 1		<b>16. SOCIAL SECURITY NO.</b> UNKNOWN		<b>17. INFORMANT</b> Address MRS. EDWARD CALLIS MT. LAKE PARK, MD.			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> Benedict Skitarelic, M.D.				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> May 18, 1961				<b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> BURIAL		<b>22b. DATE THEREOF</b> MAY 23, 1961		<b>22c. NAME OF CEMETERY OR CREMATORY</b> ARLINGTON NATIONAL CEM.		<b>22d. LOCATION</b> (City, town, or county) (State) ARLINGTON, VA.	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> BYRON KIGHT				<b>ADDRESS</b> CUMBERLAND, MD.		<b>24a. REC'D BY REGISTRAR</b> MAY 22 '61	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>				<b>DATE</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BOOK

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, symptoms, and examination findings. Includes checkboxes for various conditions and a large area for the examiner's notes.

Vertical text on the right margin, possibly a date or reference number: 8-10-1934

## CERTIFICATE OF DEATH

Reg. Dist. No. **65054**

5064

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>45 Weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>BENJAMIN</b> Last <b>SITES</b>				4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>19 61</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-5-1889</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Kelly Worker Kelly Tire Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Springfield Shaw, W.Va.</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank Sites</b>				14. MOTHER'S MAIDEN NAME <b>Betty Arnold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>214-07-1611</b>			
17. INFORMANT <b>Mrs. Harry Sites, Eckhart, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis &amp; kidney dis</b> (c) <b>Years</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>5/18</b> , 19 <b>61</b> , to <b>5/29</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/29/61</b> , 19 <b>61</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 B road way</b> DATE SIGNED <b>5/29/61</b>							
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>				PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D., Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5/31/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Eckhart Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hefer Funeral Home</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 2 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5065

Item 9 Film G286 6/2/61 iwk

05055

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CIMBERLAND</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		
c. LENGTH OF STAY IN 1b <b>18 days</b>			d. STREET ADDRESS <b>285 E. MAIN STREET</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>W</b> Last <b>SLOAN</b>			4. DATE OF DEATH Month <b>5</b> Day <b>24</b> Year <b>1961</b>		
5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8-14-1880</b>		
9. AGE (In years, last birthday) <b>80 1/2 yrs.</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work during working life, even if retired) <b>Retired Alteration work</b>			11. BIRTHPLACE (Country & State, or foreign country) <b>MARYLAND</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JAMES SLOAN</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET CARROLL</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-05-8334</b>		
17. INFORMANT <b>James Sloan, c/o Gunter Hotel</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerosis Heart Disease</b> DUE TO (c) <b>embolism</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Scrub typhus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>5/5/61</b> to <b>5/20/61</b> , that (I) (we) last saw the deceased alive on <b>5/23/61</b> , and that death occurred at <b>7:25 P.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>			22b. DATE SIGNED <b>5/24/61</b>		
22c. PHYSICIAN'S NAME (Type) <b>S.G. WEISMAN</b>			22d. ADDRESS <b>59 GREENE STREET</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/27/61</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Frostburg Md.</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Montecant</b>			25. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		
25a. REC'D BY REGISTRAR <b>MAY 31 '61</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

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October 5, 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5066

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05056

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>59 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>127 Independence Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Audrey</b> Middle <b>Zenobia</b> Last <b>Sluss</b>				4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1902</b>	
9. AGE (In years lost birthday) yrs. <b>59</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
13. FATHER'S NAME <b>Charles Matlick</b>				14. MOTHER'S MAIDEN NAME <b>Almyra Wilhelm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William C. Sluss Sr</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of uterus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 10, 1961</b> to <b>May 14, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 14, 1961</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>May 15 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>				22d. ADDRESS <b>Cumberland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 17, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

1000

CERTIFICATE OF DEATH

2000



CHIEF CLERK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled out by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5067  
65057  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>1 Hr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		d. STREET ADDRESS <b>Route 1, Frostburg,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Leo</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7th</b> , 19 <b>61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 11th, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Employer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Smith</b>		14. MOTHER'S MAIDEN NAME <b>Rose Ann Drumm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>213-05-7128</b>	
17. INFORMANT <b>Mrs. Katherine L. Smith, Rt. 1, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma</b> 181.0 DUE TO <b>Carcinoma Bladder</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b> <b>2 years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>May 7</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>May 5</b> , 19 <b>61</b> , and that death occurred <b>6:00 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>W O McLane</b>		22b. DATE SIGNED <b>May 9 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>		22d. ADDRESS <b>167 E. Main Street, Frostburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Russell</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 10 '61</b>	
ADDRESS <b>Frostburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5068

05058

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL FLINTSTONE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL FLINTSTONE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROUTE 1,</b>		d. STREET ADDRESS <b>ROUTE 1,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DELLA</b> Middle <b>SOWERS</b> Last		4. DATE OF DEATH Month <b>MAY</b> Day <b>28</b> Year <b>19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 7, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>FLOYD CROW</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ALVA SOWERS, ROUTE 1, FLINTSTONE, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wound</b> <b>444X</b> DUE TO <b>gunshot arteriole</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hypertension</b> (b) <b>Hypertension</b> (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>gun</b> <b>gun</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 20, 1961</b> to <b>May 28, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 20, 1961</b> and that death occurred at <b>10:00</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>B. M. Schindler</b>		22b. DATE SIGNED <b>5-29-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. M. SCHINDLER, M. D.</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 31, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>POCAHONTAS CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>POCAHONTAS, PA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>	
25a. REC'D BY REGISTRAR <b>JUN 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneiss</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05059**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 CUMBERLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1820 BEDFORD ST.</b>				d. STREET ADDRESS <b>1820 BEDFORD ST.</b>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>LEAH</b> Middle <b>W.</b> Last <b>SPOERL</b>				<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>4</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>Nov. 7, 1912</b>		9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>CHARLES C. WILLISON</b>			
14. MOTHER'S MAIDEN NAME <b>ALICE ROBINSON</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>FRANK SPOERL CUMBERLAND, MD.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, LEFT</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>CORONARY OSTEOCLEROSIS</b> (c) <b>420.1</b> DUE TO <b>420.1</b> (c) <b>420.1</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>CUMBERLAND, MD.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 4, 1961</b>					
EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>			
22d. LOCATION (City, town, or county) <b>CUMBERLAND, MD.</b>		22e. LOCATION (State) <b>MARYLAND</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		ADDRESS <b>CUMBERLAND, MD.</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. PHYSICAL EXAMINATION

4. LABORATORY TESTS

5. PATHOLOGICAL FINDINGS

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF EXAMINER

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF REGISTRAR

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05060

5070

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>35 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROUTE 1, VALLEY ROAD</b>		e. STREET ADDRESS <b>ROUTE 1, VALLEY ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE VERNON STEELE</b>		4. DATE OF DEATH Month Day Year <b>MAY 11 19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 30, 1894</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSE PAINTING</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES STEELE</b>		14. MOTHER'S MAIDEN NAME <b>LAURA WOODS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 058389</b>	
17. INFORMANT <b>MARY STEELE, ROUTE 1, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 11, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 14, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>		22d. LOCATION (City, town, or county) (State) <b>CUMBERLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT</b>		24a. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1008

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		SIGNATURE OF EXAMINER	
DISEASE OR INJURY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM EXAMINATION		FINDINGS		REMARKS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF DENTIST		SIGNATURE OF NURSE		SIGNATURE OF MIDWIFE		SIGNATURE OF OTHER	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESSES		SIGNATURE OF JURY	
DATE OF BURIAL		TIME OF BURIAL		PLACE OF BURIAL		SIGNATURE OF EXAMINER		SIGNATURE OF WITNESSES		SIGNATURE OF JURY	

5001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5071

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65061

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>8 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>131 Independence Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Swan</b> Last <b>Swan</b>		4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1878</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas McBride</b>		14. MOTHER'S MAIDEN NAME <b>Rachel McMasters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>131 Independence Street, Mrs. S. Leroy Durst, Cumberland, Maryland</b>	
17. INFORMANT <b>131 Independence Street, Mrs. S. Leroy Durst, Cumberland, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Repeated Cerebral Thromboses, small</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b> <b>8 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/27</b> , 19 <b>61</b> , to <b>5/30</b> , 19 <b>61</b> ; that (I) (we) last saw the deceased alive on <b>5/27</b> , 19 <b>61</b> , and that death occurred at <b>11 P.</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Allegany</b>		22b. DATE SIGNED <b>5/31/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>57 Greene St Cumberland, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 2, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Lee Silcox</b>		25a. REC'D BY REGISTRAR <b>JUN 5 '61</b>	
ADDRESS <b>Cumberland Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5072											
05062											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WEST VIRGINIA MINERAL</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>10 HOURS</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVENUES</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>IRA A. THOMAS</b>				4. DATE OF DEATH <b>MAY 10 1961</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 4, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Retailer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Mdse</b>				11. BIRTHPLACE (County & State, or foreign country) <b>NEBRASKA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ANDREW THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>MARTHA WYMORE</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>720-18-3284</b>				17. INFORMANT Address <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterio Sclerosis Cerebral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Chronic a.s.c.v.d.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>approx. 1 day</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>approx. May 10, 1961</b> to <b>May 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 10, 1961</b> , and that death occurred at <b>12:40 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>John A. Topper</b>				22b. DATE SIGNED <b>5-11-61</b>							
22c. PHYSICIAN'S NAME (Type) <b>DR. JOHN A. TOPPER</b>				22d. ADDRESS <b>HYNDMAN, PA.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/13/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Levels, W. Va.</b>		23d. LOCATION (City, town or county) (State) <b>Levels, Hampshire, W. Va.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>PAKKS-JOHNSON</b>				ADDRESS <b>BERKELEY SPRINGS, W. Va.</b>				25a. REC'D BY REGISTRAR <b>MAY 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

05068

3703



ALLEGANY

WEST VIRGINIA

LOW PAID

10 HOURS

CHANDLER

MENTAL HOSPITAL  
1500 R. & MENDALL AVENUE

WAY TO 10

THOMAS

HR

PERMANENT 1887

WHITE

U.S.A.

REMARKS

See above

Resident Hospital

WORTH WOODS

ALFRED THOMAS

1500-25-2500 - MENTAL HOSPITAL - CHANDLER

20



12:00 PM

WYOMING

DR. JOHN A. TOWNE

5/13/61

CHANDLER

Lowell, Tennessee

ALLEGANY COUNTY MENTAL HOSPITAL

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05063

5073

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>2 HRS. 25 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>1 S. WAVERLY TERRACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>Stoan</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 2, 1889</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>		11. BIRTHPLACE (County & State, or foreign country) <b>KANSAS , Opeto</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ANDREW THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>ALICE WYMORE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis &amp; Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>7 yrs</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19 54</b> to <b>May 13, 19 61</b> , that (I) (we) last saw the deceased alive on <b>May 13, 19 61</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Clay E. Durrett M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/13/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>				22d. ADDRESS <b>236 VIRGINIA AVENUE, CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Catholic Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAY 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hauser</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

11

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

5 HRS. 35 MIN.

CUMBERLAND

MEMORIAL HOSPITAL

1 34 Waverly Terrace

JAMES

THOMAS

WAY

10

WHITE

WHITE

WAY 2, 1933

75

RETIRED Teacher

1912-1914

IN 1933, 0-0-0

U.S.A.

ALICE THOMAS

ALICE THOMAS

MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

*Handwritten notes and signatures, mostly illegible.*

DR. CLAY DURRETT

335 VIRGINIA AVE. N.E., CUMBERLAND, MD.

John L. Lee, Jr., Cumberland, Maryland

Dr. Lee's Office, Cumberland, Maryland

1912-1914



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

65064

5074

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
c. LENGTH OF STAY IN 1b <b>75Yrs.</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>308 Central Ave.</b>				d. STREET ADDRESS <b>308 Central Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>JOHN HENRY TROST</b>				4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1880</b>		9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Samuel H. Trost</b>				14. MOTHER'S MAIDEN NAME <b>Anna Geldhaus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss. Mildred Trost</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <b>4-3</b> , <b>1961</b> , to <b>5-4</b> , <b>1961</b> , that I last saw the deceased alive on <b>5-2</b> , <b>1961</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lewis Brings</b>				ADDRESS (Street, city or town, state) <b>57 Greene St. Cumberland Md</b>		DATE SIGNED <b>5-5-61</b>	
PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 6, 1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 8 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar		11. Signature of witness	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 65065

5075

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 3 Cumberland,</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bedford Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>BELLE</b> Last <b>VALENTINE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Chaneyville, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Bridges</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Bartholow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Carl Valentine</b>		Address <b>Rt. # 3 Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis &amp; Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 May, 1961</b> , to <b>26 May, 1961</b> , that I last saw the deceased alive on <b>1 May, 1961</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>441 N. Centre St.,</b> DATE SIGNED ACTUAL SIGNATURE <b>William P. James</b> M.D. PHYSICIAN'S NAME (Type) <b>William P. James M.D.</b> <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/29/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 31 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

CERTIFICATE OF DEATH

100-100000

100-100000

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Race: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Manner of death: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of registration: [illegible]

5076

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G288

6/6/61 JWC

Reg. Dist. No.

05066

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>35 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>506 PARK ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEIMAN ABEL VEACH</b>				4. DATE OF DEATH Month Day Year <b>MAY 26 19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 9, 1903</b>	
9. AGE (In years last birthday) <b>56 57 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REPAIRMAN</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN A. VEACH</b>				14. MOTHER'S MAIDEN NAME <b>KATHRYN JACK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. JOHN VEACH CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b> DUE TO <b>9774 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PLASTIC BAG OVER X HEAD</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3-5 Min.</b> <b>3-5 Min.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>May 26, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 29, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HIGH CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>CUMBER PURGITSVILLE, W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BYRON KIGHT CUMBERLAND, MD.</b>				24a. REC'D BY REGISTRAR <b>JUN 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

63088

MASSACHUSETTS DEPARTMENT OF HEALTH-CARE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1975

M

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE	
11. PRESENT ADDRESS		12. DATE OF DEATH		13. TIME OF DEATH		14. PLACE OF DEATH		15. CAUSE OF DEATH	
16. MANNER OF DEATH		17. SIGNATURE OF EXAMINER		18. SIGNATURE OF WITNESS		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF NURSE		25. SIGNATURE OF CHAPLAIN	
26. SIGNATURE OF SOCIAL WORKER		27. SIGNATURE OF CLERGY		28. SIGNATURE OF MINISTER		29. SIGNATURE OF RABBI		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER	
36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER	
56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER	
66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER	
86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER	
96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

William J. Kram

VR A15 (4)  
15M 9/60



1000

1000

M

1

ALLIANCE

MEMORIAL

ALLIANCE

DEPT. OF HEALTH

7 DAYS

OVERLAND

DEPARTMENT OF HEALTH

MEMORIAL & WARREN HOSPITAL

1945

WARRIOR

DEPT. OF HEALTH

TO

1945-1946

WHITE

U. S. A.

WEST VIRGINIA

DEPT. OF HEALTH

HEALTH DEPT.

DEPT. OF HEALTH

WILLIAM WARRIOR

1945-1946 MEMORIAL HOSPITAL - OVERLAND, MO.

*[Faint, illegible handwritten text]*

1945

1945 VIRGINIA AVE., OVERLAND, MO.

1945 VIRGINIA AVE., OVERLAND, MO.

1945 VIRGINIA AVE., OVERLAND, MO.

1945 VIRGINIA AVE., OVERLAND, MO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
5078  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
05068

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Robbins Street</b>		d. STREET ADDRESS <b>Robbins Street</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>WILAND</b> Last <b>WILAND</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5th.</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug, 30th, 1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Barton, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Leyden</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Lashbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John Wiland</b>		Address <b>Lonaconing, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypothyroidism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1956</b> to <b>May 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1961</b> , and that death occurred at <b>1 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L.R. Miles, Jr. M.D.</b>		22b. DATE SIGNED <b>5-6-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>		22d. ADDRESS <b>LONA CONING MD</b>	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/8/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		ADDRESS <b>LONA CONING, MD.</b>	
25a. REC'D BY REGISTRAR DATE <b>MAY 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

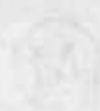
21

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5079  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
061  
u5069

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X R-F-D.#1 Frostburg, MD.</b>	
c. LENGTH OF STAY IN 1b <b>10 Days</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>WILSON</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>5/29/1961</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/31/1876</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months <b>84</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nohe</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Workman</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Schriff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Arthur Lemmert, Mt. Savage, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO <b>Anteriosclerotic Cardio-vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5.18 1961</b> to <b>5.29 1961</b> , that (I) (we) last saw the deceased alive on <b>5.29 1961</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L.R. Miles, Jr., M.D.</b>		22b. DATE SIGNED <b>6.1.61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR., M.D.</b>		22d. ADDRESS <b>Lonaconing, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/1/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		25a. REC'D BY REGISTRAR <b>LONACONING, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>DATE JUN 5 '61</b>		25c. REGISTRAR'S SIGNATURE <b>Charles J. Hower</b>	

RECEIVED  
[REDACTED]  
[REDACTED]  
[REDACTED]

1078



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5080

65070

1. PLACE OF DEATH e. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 HOUR</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <b>308 MT. VIEW DRIVE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ORION</b> Middle <b>OLIVER</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 4, 1878</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b>		IF UNDER 24 HRS. Hours <b>83</b> Min. <b>83</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hardware Store</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>							
13. FATHER'S NAME <b>OLIVER WILSON</b>				14. MOTHER'S MAIDEN NAME <b>Emma FISHER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-32-3422</b>			
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Coronary arteriosclerosis</b> DUE TO <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Duodenal ulcer; myocardial fibrosis; left ventricular hypertrophy</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19 50</b> to <b>May 14 19 61</b> , that (I) (we) last saw the deceased alive on <b>May 14 19 61</b> , and that death occurred at <b>4:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Samuel Jacobson</b>				22b. DATE SIGNED <b>5/15/61</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. SAMUEL JACOBSON</b>	
22d. ADDRESS <b>50 Pershing St. Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>intombment</b>		23b. DATE THEREOF <b>May 17, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>				ADDRESS <b>117 Frederick St. Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>							

MEDICAL CERTIFICATION

(M)

(I)

ALLEGANY

CUMBERLAND

MEMORIAL HOSPITAL

BRIDG

WHITE

OLIVER WILSON

SMITH & MEMORIAL  
AVES.

OLIVER

WILSON

APRIL 1, 1928

CUMBERLAND, MARYLAND

FISHER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

Interment May 17, 1901 Rose Hill Cemetery

Cumberland, Maryland

Interment May 17, 1901 Rose Hill Cemetery

Cumberland, Maryland



may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5081

05071

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eckhart</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Jane</b> Last <b>Wright</b>				4. DATE OF DEATH Month <b>May</b> Day <b>8th</b> , Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 28th, 1879</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b>		IF UNDER 24 HRS. Months <b>81</b> Days <b>81</b> Hours <b>81</b> Min. <b>81</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Pape</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Susan Coppage</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Upton Loar, Eckhart, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1 1961</b> to <b>May 8 1961</b> , that (I) (we) last saw the deceased alive on <b>May 7 1961</b> , and that death occurred on <b>May 8 1961</b> at <b>2:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>W. O. McLane</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 9 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>				22d. ADDRESS <b>167 E. Main St., Frostburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Dunsen</b> ADDRESS <b>Frostburg, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. K...</b>	

(M)

X

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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5082

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65072

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10/II/56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. STREET ADDRESS <b>325 Holland Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Alvey</b> Middle <b>Gerald</b> Last <b>Zembower</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/9/79</b>
9. AGE (In years lost birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam W. Zembower</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Rose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>P.O.Box. 899</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypostasis</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Cerebral Hemorrhage</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>?</b> <b>?</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/II/56</b> , 19____, to <b>5/IO/61</b> , 19____, that (I) (we) lost saw the deceased alive on <b>5/9/61</b> , 19____, and that death occurred at <b>7:00 A.M.</b> on the date stated above.			
22a. SIGNATURE <b>James E. McLean</b>		22b. DATE SIGNED <b>5/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 12, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein, Inc.</b>		25a. REC'D BY REGISTRAR <b>MAY 15 61</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	

